Provider Communication

Subject:	New GMAC Changes Effective 7/01/2007	**Priority:**	**High**
Date:	May 22, 2007	**Message ID:**	ACSBNR05222007_2

Dear Pharmacy Provider:

New GMAC Changes Effective 7/01/2007

Additional changes to the GMAC list will become effective July 1, 2007. They include price decreases, increases, additions and deletions. The July 1, 2007 GMAC changes will be available for review on or after June 1, 2007 at **www.ghp.georgia.gov**. Go to Providers, then Pharmacy Overview, and click on GMAC.

VERY IMPORTANT NPI UPDATE

The **Department of Community Health Pharmacy** Unit will **not** require submission of the **N**ational **P**rovider **I**dentifier (NPI) for electronic pharmacy transactions on May 23, 2007. During the 12-month extension recently granted by DHHS, DCH will publish communications regarding our approach to NPI implementation and the effective dates of these changes. The goal is to provide an adequate run-in period prior to May 23, 2008 to allow dual submission of legacy identifiers or NPI. Providers will be notified via banner of the date upon which DCH will allow dual submission of these identifiers as well as further instructions. Providers who have not done so are encouraged to obtain their NPI and **submit the NPI to DCH.** NPIs may be obtained at https://nppes.cms.hhs.gov/NPPES.

Directions for submission to DCH:
All active Georgia Medicaid providers must supply their NPI to Georgia Medicaid .
After receiving their NPI(s) all Georgia Medicaid Providers must submit their NPI(s) using the Georgia Medicaid National Provider Identifier (NPI) Submittal Form which is available on the GHP Web Portal under Provider Information – Documents and Forms. The complete submittal form must be submitted with a copy of the NPI confirmation letter from the NPPES to:

Mail: ACS Provider Enrollment Unit
Post Office Box 4000
McRae, Georgia 31055 Fax: 1-866-309-0935

NOMINATIONS FOR DURB

The Georgia Department of Community Health (DCH) is seeking recommendations for appointment to the Drug Utilization Review Board (DURB). These appointments will have an effective date of October 1, 2007 and service duration of two (2) years.

The DURB was established under the authority of Section 1903 (3) A of the Omnibus Budget Reconciliation Act of 1990, (OBRA '90). The Board's purpose is to make recommendations to the Department regarding various aspects of the pharmacy benefit services provided to members of Georgia Medicaid. Additionally, the Department provides an annual report to the Centers for Medicare and Medicaid Services (CMS) that describes the yearly activities of the Board.

Members' duties may include reviews of medical criteria and standards as well as recommendations for educational intervention methods and preferred drug list status determination. The Board gathers information relating to drug therapy and outcome assessments in order to identify opportunities for more efficient drug utilization and cost-effective therapies while decreasing adverse events in consideration of regulatory requirements. All members serve at the pleasure of the Commissioner.

Nominees submitting information for appointment to the twenty-member Board will be considered based on areas of expertise and varied practice sites involving the prescribing, dispensing, teaching and monitoring of outpatient medications. Each member is appointed by the Commissioner to a two (2) year term and is paid an hourly rate per meeting, preparation and attendance plus round trip travel mileage.

Please forward the names of persons that you or your organization wishes to recommend for appointment. The Department requests a biographical sketch or curriculum vitae to accompany each nomination that includes the nominee's address, telephone number, and any special professional qualifications.

Nominations should be submitted to Ms. Patricia Jeter, MPA, RPh, no later than **May 31, 2007**,

at this address:

Department of Community Health

Pharmacy Services – 37th Floor

2 Peachtree Street, N.W.

Atlanta, Georgia 30303 -3159

Your assistance and cooperation in this matter is greatly appreciated. If you have questions specific to this communication, please contact the SXC Technical Call Center at 1-866-525-5826. We thank you for your continued service and participation in the Georgia Medicaid & Peach Care for Kids Programs. Please share this information with appropriate staff. If you are the corporate office of a chain pharmacy, please provide this information to each of your stores located in Georgia.

Division of Medical Assistance

Pharmacy Services Unit 404-656-4044

GA Medicaid

SXC Health Solutions, Inc.
PO Box 3214
Lisle, IL 60532-8214

PAYER SPECIFICATION SHEET

6/1/07

Bin #:	001553
States:	All GA willing Providers
Destination:	SXC (ComCoTec) / RxClaim
Accepting:	Claim Adjudication, Reversals
Format:	NCPDP Version 5.1

CHANGES:

Other Coverage Codes 5-8 added in field 308-C8. Field 433-DX PATIENT PAID AMOUNT SUBMITTED has been changed from 'Not Required' to 'Required When Submitting for Other Insurance Copay and Using Other Coverage Code 8'. –Effective date- 6/1/07

1. Segment And Field Requirements By Transaction Type

BILLING (B1), REVERSAL (B2), and REBILLING (B3) TRANSACTION DATA ELEMENTS

(M-Mandatory, S-Situational, ***R-Repeat Field)

Transaction Header Segment - Mandatory			Segment is Required
NCPDP Field	**Field Name**	**Mandatory or Situational**	**COMMENTS/VALUES**
1Ø1-A1	BIN NUMBER	M	001553
1Ø2-A2	VERSION/RELEASE NUMBER	M	51
1Ø3-A3	TRANSACTION CODE	M	B1, B2 or B3 only
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	GAM
1Ø9-A9	TRANSACTION COUNT	M	01 – 04 (up to 4 transactions per B1 & B3 transmission) accepted; Only 01 for a B2 transaction
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	05 (Medicaid) or 07 (NCPDP)
2Ø1-B1	SERVICE PROVIDER ID	M	Value for the qualifier used in 202-B1 above
4Ø1-D1	DATE OF SERVICE	M	CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	Use value for Switch's requirements. If submitting claim without a Switch, populate with blanks.

Patient Segment – Situational			Client REQUIRES Segment for B1, B2, and B3 transactions to locate correct member.
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	01 – transmit ONLY if the segment is transmitted.
331-CX	PATIENT ID QUALIFIER	S	Not Required
332-CY	PATIENT ID	S	Not Required
3Ø4-C4	DATE OF BIRTH	M	Required
3Ø5-C5	PATIENT GENDER CODE	S	Captured if sent though not required
31Ø-CA	PATIENT FIRST NAME	S	Captured if sent though not required
311-CB	PATIENT LAST NAME	S	Captured if sent though not required
322-CM	PATIENT STREET ADDRESS	S	Captured if sent though not required
323-CN	PATIENT CITY ADDRESS	S	Captured if sent though not required
324-CO	PATIENT STATE / PROVINCE ADDRESS	S	Captured if sent though not required
325-CP	PATIENT ZIP/POSTAL ZONE	S	Captured if sent though not required
326-CQ	PATIENT PHONE NUMBER	S	Captured if sent though not required
3Ø7-C7	PATIENT LOCATION	S	Captured if sent though not required
333-CZ	EMPLOYER ID	S	Captured if sent though not required
334-1C	SMOKER / NON-SMOKER CODE	S	Captured if sent though not required
335-2C	PREGNANCY INDICATOR	S	Captured if sent though not required

Insurance Segment – Situational			Segment is Required for B1 and B3 transactions. Not Required for B2 transaction.
NCPDP	**Field Name**	**Mandatory or**	

Field		Situational	
111-AM	SEGMENT IDENTIFICATION	M	04 – transmit ONLY if the segment is transmitted.
3Ø2-C2	CARDHOLDER ID	M	Enter member's 12 digit ID from Medicaid ID card
312-CC	CARDHOLDER FIRST NAME	S	Captured if sent though not required
313-CD	CARDHOLDER LAST NAME	S	Captured if sent though not required
314-CE	HOME PLAN	S	Captured if sent though not required
524-FO	PLAN ID	S	Captured if sent though not required
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	S	Captured if sent though not required
336-8C	FACILITY ID	S	Captured if sent though not required
3Ø1-C1	GROUP ID	S	Captured if sent though not required
3Ø3-C3	PERSON CODE	S	Not Required
3Ø6-C6	PATIENT RELATIONSHIP CODE	S	Not Required

Claim Segment – Mandatory			Segment is Required for B1, B2, B3 transactions.
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	07 – transmit ONLY if the segment is transmitted.
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Required Only value '1' is accepted.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Required Only supports 7 digit Rx #.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	03 – NDC 01 -UPC
4Ø7-D7	PRODUCT/SERVICE ID	M	11-digit NDC Number 12-digit UPC Code
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #	S	Required on partial or completion fills
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE	S	Required on partial or completion fills
458-SE	PROCEDURE MODIFIER CODE COUNT	S	Not Required
459-ER	PROCEDURE MODIFIER CODE	S***R***	Not Required
442-E7	QUANTITY DISPENSED	S	Required for B1 & B3 claims.
4Ø3-D3	FILL NUMBER	S	Required for B1 & B3 claims.
4Ø5-D5	DAYS SUPPLY	S	Required for B1 & B3 claims.
4Ø6-D6	COMPOUND CODE	S	Required for B1 & B3 claims. Use '2' if product is a compound.
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	S	Required for B1 & B3 claims. '1' only for limited products Do not use 2, 3, 4, 5, 6, 7, 8 or 9
414-DE	DATE PRESCRIPTION WRITTEN	S	Required for B1 & B3 claims.
415-DF	NUMBER OF REFILLS AUTHORIZED	S	Captured if sent though not required

419-DJ	PRESCRIPTION ORIGIN CODE	S	Captured if sent though not required
42Ø-DK	SUBMISSION CLARIFICATION CODE	S	Captured if sent though not required
46Ø-ET	QUANTITY PRESCRIBED	S	Required on partial or completion fills
3Ø8-C8	OTHER COVERAGE CODE	S	**Ø=Not Specified** **1=No other coverage identified** **2=Other coverage exists-payment collected** **3=Other coverage exists-this claim not covered** **4=Other coverage exists-payment not Collected** **5=Managed care plan denial** **6=Other coverage denied-not a participating provider** **7=Other coverage exists-not in effect at time of service** **8=Claim is a billing for a copay *** ***Note: Submit the copay amount in the 433-DX Patient Paid Amount Submitted Field.**
429-DT	UNIT DOSE INDICATOR	S	Not Required
453-EJ	ORIG PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	Not Required
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	Not Required
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	Not Required
33Ø-CW	ALTERNATE ID	S	Not Required
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	Not Required
6ØØ-28	UNIT OF MEASURE	S	Not Required
418-DI	LEVEL OF SERVICE	S	Not Required
461-EU	PRIOR AUTHORIZATION TYPE CODE	S	04:

			Emergency Fill Indication* New Nursing Facility Members* Newly DX Pregnant Women* 08: Member is diagnosed with Breast or Cervical Cancer* *Note: 462-EV must be submitted with a following appropriate code
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	99888 Emergency Fill Indication 11111 New Nursing Home Indicator 22222 Newly DX pregnant woman 00000 Breast or Cervical Cancer diagnosis
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	Not Required
464-EX	INTERMEDIARY AUTHORIZATION ID	S	Not Required
343-HD	DISPENSING STATUS	S	Blank=Not Specified P=Partial Fill C=Completion of Partial Fill
344-HF	QUANTITY INTENDED TO BE DISPENSED	S	Required on partial or completion fills
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	S	Required on partial or completion fills

Pharmacy Provider Segment – Situational			Segment is Not Required
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	02 – transmit ONLY if the segment is transmitted.
465-EY	PROVIDER ID QUALIFIER	S	Captured if sent though not required
444-E9	PROVIDER ID (NCPDP #)	S	Captured if sent though not required

Prescriber Segment – Situational			Segment is Required for B1 and B3 transaction.
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	03
466-EZ	PRESCRIBER ID QUALIFIER	S	08
411-DB	PRESCRIBER ID	S	Georgia License Number – Required When actual License Number unavailable: PDO300 Podiatrists, Dentists, Optometrists GHS300 Grady Health System Hospital, Clinics, Emergency Rooms AOH300 All other Hospitals, Clinics or Emergency Rooms AOS300 All Out of State Providers ANP300 All New Physician License Number (Granted within the last 60 days)
467-1E	PRESCRIBER LOCATION CODE	S	Captured if sent though not required
427-DR	PRESCRIBER LAST NAME	S	Captured if sent though not required
498-PM	PRESCRIBER PHONE NUMBER	S	Captured if sent though not required
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	Captured if sent though not required
421-DL	PRIMARY CARE PROVIDER ID	S	Captured if sent though not required
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	Captured if sent though not required
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME	S	Captured if sent though not required in adjudication

COB/Other Payments Segment – Situational			Segment is Required ONLY if COB or Coupons apply to the Claim. Not Required for B2 transaction.
NCPDP Field	**Field Name**	**Mandatory or**	

		Situational	
111-AM	SEGMENT IDENTIFICATION	M	05 – transmit ONLY if the segment is transmitted.
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Required if Segment is Used. Maximum = 3.
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	Required if Segment is Used.
339-6C	OTHER PAYER ID QUALIFIER	S***R***	Required if Segment is Used.
34Ø-7C	OTHER PAYER ID	S***R***	Required if Segment is Used.
443-E8	OTHER PAYER DATE	S***R***	Required
341-HB	OTHER PAYER AMOUNT PAID COUNT	S	Required if Segment is Used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	S***R***	Required if Segment is Used.
431-DV	OTHER PAYER AMOUNT PAID	S***R***	Required if Segment is Used.
471-5E	OTHER PAYER REJECT COUNT	S	Not Required
472-6E	OTHER PAYER REJECT CODE	S***R***	Not Required

Workers' Compensation Segment – Not used at this time	**Not used at this time**

DUR/PPS Segment -- Situational			Segment is Not Required Use encouraged if applicable. Not required for B2 transaction.
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	08 – transmit ONLY if the segment is transmitted.
473-7E	DUR/PPS CODE COUNTER	S***R***	Required if segment used. One to 9 occurrences are supported.
439-E4	REASON FOR SERVICE CODE	S***R***	Required if segment used.
44Ø-E5	PROFESSIONAL SERVICE CODE	S***R***	Required if segment used.

441-E6	RESULT OF SERVICE CODE	S***R***	Required if segment used.
474-8E	DUR/PPS LEVEL OF EFFORT	S***R***	Not Required
475-J9	DUR CO-AGENT ID QUALIFIER	S***R***	Required if 476-H6 used. Values 01, 02, 03, 20.
476-H6	DUR CO-AGENT ID	S***R***	Encouraged if code DC, DD, ID, MC, TD in 439-E4.

Pricing Segment – Mandatory			Segment is Required for B1 and B3 transactions. Not Required for B2 transaction.
NCPDP Field	**Field Name**	**Mandatory or Situational**	
111-AM	SEGMENT IDENTIFICATION	M	11 – transmit ONLY if the segment is transmitted.
4Ø9-D9	INGREDIENT COST SUBMITTED	S	Required
412-DC	DISPENSING FEE SUBMITTED	S	Required
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	Not Required
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	Required When Submitting for Other Insurance Copay and Using Other Coverage Code 8.
438-E3	INCENTIVE AMOUNT SUBMITTED	S	Not Required
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S	Required if 480-H9 submitted.
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***R***	Required if 480-H9 submitted.
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	S***R***	Not Required
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	Required in applicable locations.
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	Required in applicable locations.
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	Required if 482-GE submitted.
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	Required if 482-GE submitted.
426-DQ	USUAL AND CUSTOMARY CHARGE	S	Required

43Ø-DU	GROSS AMOUNT DUE	S	Required
423-DN	BASIS OF COST DETERMINATION	S	Not Required

Coupon Segment – Not Used at this time	**Not used at this time**

Prior Authorization Segment – Not used at this time	**Not used at this time**

Clinical Segment – Not used at this time	**Not used at this time**

NOTE: A "Situational" data element means the NCPDP Standard does not require data on all claims, but the PLAN SPONSOR reserves the possibility of use in specific claim situations. The 'Mandatory" and "Required" fields within a "Situational" segment are only mandatory IF the segment is being utilized.

Situational segments can be transmitted; however, not all segments are supported. Please contact the information number for more information regarding the support of claim segments.

- This client does NOT SUPPORT eligibility verification transactions.
- This client does NOT SUPPORT prior authorization transactions.
- The use of the Prior Authorization Segment is NOT SUPPORTED.
- This client does NOT SUPPORT informational transactions
- This client does NOT SUPPORT controlled substance reporting transaction
- Single Line Compounds only

NDC of the most expensive ingredient

DISPENSING FEE SUBMITTED

- Please include your dispensing fee in field 412-DC

DUPLICATE CLAIM

- A new denial reason of 88 DUPRX will post for a duplicate prescription filled at a different pharmacy. Please call the Technical Help Desk if you need more information on the other script causing the conflict.

2. GENERAL INFORMATION

Live Date:	January 1, 2007	
Maximum prescriptions per transaction:	4	
Technical assistance, help desk:	(866) 525-5826	SXC Health Solutions, Inc.
Clinical Prior Authorization support:	(866) 525-5827	SXC Health Solutions, Inc.
Toll Free Prior Authorization Fax Number:	(888)-491-9742	SXC Health Solutions, Inc.
Vendor certification required:	Yes	
Pharmacy Registration with Payer Required:	Yes	
Switch Support:	NDC ENVOY ERx QS1	

3. OTHER INFORMATION

Prescriber ID – State License is required entry for Prescriber ID.

SXC-RxCLAIM provides on-line prospective DUR edits for all of their plans. Please contact the Help Desk for further information.

DUR/PPS Segment

The DUR/PPS Segment contains data pertinent to the professional service being billed or for a DUR conflict resolution.

The Reason for Service, Professional Service and Result of Service Code fields are repeating fields and allow for multiple occurrences to be submitted.

Field	Field Name	Status	Value
111-AM	Segment Identification	M	Ø 8=DUR/PPS
439-E4	Reason for Service Code	RW	AD=Additional Drug Needed AN=Prescription Authentication AR=Adverse Drug Reaction AT=Additive Toxicity CD=Chronic Disease Management CH=Call Help Desk CS=Patient Complaint/Symptom DA=Drug-Allergy DC=Drug-Disease (Inferred) DD=Drug-Drug Interaction DF=Drug-Food interaction DI=Drug Incompatibility DL=Drug-Lab Conflict DM=Apparent Drug Misuse DS=Tobacco Use ED=Patient Education/Instruction ER=Overuse EX=Excessive Quantity HD=High Dose IC=Iatrogenic Condition ID=Ingredient Duplication LD=Low Dose LK=Lock In Recipient LR=Underuse MC=Drug-Disease (Reported) MN=Insufficient Duration MS=Missing Information/Clarification MX=Excessive Duration NA=Drug Not Available NC=Non-covered Drug Purchase ND=New Disease/Diagnosis

			NF=Non-Formulary Drug NN=Unnecessary Drug NP=New Patient Processing NR=Lactation/Nursing Interaction NS=Insufficient Quantity OH=Alcohol Conflict PA=Drug-Age PC=Patient Question/Concern PG=Drug-Pregnancy PH=Preventive Health Care PN=Prescriber Consultation PP=Plan Protocol PR=Prior Adverse Reaction PS=Product Selection Opportunity RE=Suspected Environmental Risk RF=Health Provider Referral SC=Suboptimal Compliance SD=Suboptimal Drug/Indication SE=Side Effect SF=Suboptimal Dosage Form SR=Suboptimal Regimen SX=Drug-Gender TD=Therapeutic TN=Laboratory Test Needed TP=Payer/Processor Question
440-E5	**Professional Service Code**	**RW**	ØØ=No intervention AS=Patient assessment CC=Coordination of care DE=Dosing evaluation/determination FE=Formulary enforcement GP=Generic product selection MA=Medication administration MØ=Prescriber consulted MR=Medication review PE=Patient education/instruction PH=Patient medication history PM=Patient monitoring PØ=Patient consulted PT=Perform laboratory test RØ=Pharmacist consulted other source RT=Recommend laboratory test SC=Self-care consultation

			SW=Literature search/review TC=Payer/processor consulted TH=Therapeutic product interchange
441-E6	Result of Service Code	RW	ØØ=Not Specified 1A=Filled As Is, False Positive 1B=Filled Prescription As Is 1C=Filled, With Different Dose 1D=Filled, With Different Directions 1E=Filled, With Different Drug 1F=Filled, With Different Quantity 1G=Filled, With Prescriber Approval 1H=Brand-to-Generic Change 1J=Rx-to-OTC Change 1K=Filled with Different Dosage Form 2A=Prescription Not Filled 2B=Not Filled, Directions Clarified 3A=Recommendation Accepted 3B=Recommendation Not Accepted 3C=Discontinued Drug 3D=Regimen Changed 3E=Therapy Changed 3F=Therapy Changed-cost increased acknowledged 3G=Drug Therapy Unchanged 3H=Follow-Up/Report 3J=Patient Referral 3K=Instructions Understood 3M=Compliance Aid Provided 3N=Medication Administered